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ABSTRACT

The General Accounting Office examined existing and anticipated concerns related to the recruitment and retention of nurse and nurses aides. Special attention was paid to the following aspects of the problem: (1) factors contributing to the current and anticipated shortage among nurses; (2) what is known about the current and projected supply of nurse aides and the factors contributing to the current and anticipated shortage; and (3) government and private efforts to improve recruitment and retention of nurse aides. The following were among the main conclusions: (1) demographic and job satisfaction factors could worsen the shortage of nurses; (2) demographic changes, low compensation, and difficult working conditions are contributing to the shortage of nurse aides; and (3) state government and private sector initiatives are seeking to address nurse aide retention and recruitment, although few initiatives have been evaluated. Additional evaluation was deemed necessary to determine which state government and private sectors initiatives have been most effective in alleviating shortages of nurses and nurse aides. More detailed data were also called for to delineate the extent and nature of nurse and nurse aide shortages to assist in planning and targeting corrective efforts. (Contains 10 tables.) (MN)

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Testimony

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NURSING WORKFORCE

Recruitment and Retention of Nurses and Nurse Aides Is a Growing Concern

Statement of William J. Scanlon
Director, Health Care Issues

G A O
Accountability * Integrity * Reliability

Chairman Jeffords, Ranking Member Kennedy, and Members of the Committee:

I am pleased to be here today as you discuss issues related to the current recruitment and retention of nursing staff, including both nurses and nurse aides, and concerns about the future supply of these workers. The health and long-term care systems in the United States rely heavily on the services of both nurses and nurse aides, the two largest groups of health care workers. Considerable attention has been given to the nurse workforce, and several witnesses recently testified before this committee's Subcommittee on Aging about nursing shortages throughout the country. Very little attention, however, has been given to the characteristics and supply of nurse aides, who provide most of the direct care for persons in nursing homes and those receiving home health care services.

To assist the Congress as it considers a range of possible federal efforts to ensure that consumers receive quality health and long-term care services, you requested that we review current data on the nurse workforce and examine in more detail the nurse aide workforce in hospitals, nursing homes, and home health care. Accordingly, my remarks will focus on (1) factors contributing to the current and anticipated shortage among nurses, (2) what is known about the current and projected supply of nurse aides and the factors contributing to the current and anticipated shortage, and (3) government and private efforts to improve recruitment and retention of nurse aides. In addition, you requested that we provide a detailed demographic, employment, wage, and benefit profile of nurse aides in the different employment settings. This information is presented in appendix I.

To provide information on the nurse workforce, we relied primarily on published reports and data from the Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA), industry and professional associations, researchers, and other experts. To develop information on the nurse aide workforce, we (1) analyzed recent data from the Bureau of Labor Statistics' (BLS) Current Population Survey (CPS) and Occupational Employment Statistics (OES); (2) interviewed experts, industry and professional association representatives, and federal and state agency officials; and (3) conducted a review of the relevant professional and research literature. We performed our work from January through May 2001 in accordance with generally accepted government auditing standards.

In summary, recruitment and retention of both nurses and nurse aides are major concerns for health care providers. Experts and providers are reporting a current shortage of nurses, partly as a result of patients' increasingly complex care needs. While comprehensive data are lacking on the nature and extent of the shortage, it is expected to become more serious in the future as the aging of the population substantially increases the demand for nurses. Moreover, several factors are combining to constrain the current and future supply of nurses. Like the general population, the nurse workforce is aging, and the average age of a registered nurse (RN) increased from 37 years in 1983 to 42 in 1998. Enrollments in nursing programs have declined over the past 5 years, shrinking the pool of new workers to replace those who are retiring. In addition, numerous studies report decreased levels of job satisfaction among nurses, potentially leading to their pursuing other occupations.

Demographic changes over the coming decades may also worsen the shortage of nurse aides in hospitals, nursing homes, and home health care settings. With the aging of the population, demand for nurse aides is expected to grow dramatically, while the supply of workers who have traditionally filled these jobs will remain virtually unchanged. According to the Institute of Medicine (IOM), advocacy groups, and provider associations, a serious shortage of nurse aides already exists. Retention of nurse aides is a significant problem for many providers, with some studies reporting annual turnover rates for aides working in nursing homes approaching 100 percent. Several factors contribute to providers' difficulty in both hiring and retaining nurse aides, including relatively low wages and few benefits. In addition, research has found that the physical demands of the work and other aspects of the workplace environment lead to difficulties in retaining nurse aides. In 1999, 30 states indicated that they were addressing nurse aide recruitment and retention through task forces, initiatives, and research. The federal government and provider groups also have begun to address this issue. However, few studies have evaluated the effectiveness of these efforts.

Background

RNs and licensed practical nurses (LPN) are responsible for a large portion of the health care provided in this country. RNs make up the largest group of health care providers, and, historically, have worked predominantly in hospitals; a smaller number of RNs work in other settings such as ambulatory care, home health care, and nursing homes. (See table 1.) Their responsibilities may include providing direct patient care in a hospital or a home health care setting, managing and directing complex nursing care in an intensive care unit, or supervising the

provision of long-term care in a nursing home. LPNs make up the second-largest group of licensed health caregivers and primarily provide direct patient care under the direction of a physician or RN. Nurse aides augment the care nurses provide by performing routine duties of caring for hospital patients or long-term care residents under the direction of an RN or LPN.[1] Most nurse aides work in nursing homes, where they provide assistance with activities of daily living such as dressing, feeding, and bathing.

Table 1: Number of RNs, LPNs, and Nurse Aides Working in Three Employment Settings, 1999

	Hospital	Nursing home	Home health care
RNs	1,280,510	150,230	108,310
LPNs	200,030	208,030	43,460
Nurse aides	388,280	695,570	344,200

Source: 1999 Employment and Wages for Selected Health Care Occupations and Industries, Bureau of Labor Statistics (BLS), Occupational Employment Statistics (OES).

Both RNs and LPNs are subject to state licensing requirements. Individuals usually select one of three ways to become an RN—through a 2-year associate degree, 3-year diploma, or 4-year baccalaureate degree program. LPN programs are 12 to 18 months in length and generally focus on basic nursing skills such as monitoring patient or resident condition and administering treatments and medications. Federal law requires states to certify nurse aides who provide care in nursing homes and for home health care agencies that receive Medicare and Medicaid reimbursement.[2] This certification can be obtained through either a nurse aide training program and a competency evaluation—a written or oral test and skills demonstration—or competency evaluation alone. A state-approved nurse aide training program must require a minimum of 75 hours of training, including at least 16 hours of supervised practical training under the direct supervision of an RN or LPN. Approximately half of the states require the nursing aide training programs to go beyond the 75-hour minimum, with several requiring over 120 hours.[3] Federal law also requires states to

[1]We use the term "nurse aide" to refer to all paraprofessional nursing staff working in hospitals, nursing homes, or home health care.

[2]42 U.S.C. Section 1395i-3 (b)(5)(A)(i)(I), 42 U.S.C. Section 1396r(b)(5)(A)(i)(I), and Section 1395bbb(a)(3)(A)(i).

[3]This information was obtained through interviews with state officials and a survey conducted in Oct. 2000 by the Paraprofessional Healthcare Institute and the National Citizens' Coalition for Nursing Home Reform.

maintain a registry of nurse aides working in nursing homes who have passed their competency evaluations; no such requirement exists for aides working in home health care.[4] For nurse aides working in hospitals, there are no federal requirements related to certification, training, competency evaluations, or a registry.

Demographic and Job Satisfaction Factors Could Worsen Shortage of Nurses

The nation's health care providers are reporting a shortage of nurses in a range of settings. Although comprehensive data are lacking to describe the nature and extent of the current shortage, there is evidence of a growing demand for nurses with skills to treat patients with complex care needs. Furthermore, shortages can affect the quality of care. The shortage is expected to worsen as the aging population increases demand and fewer people enter the nurse workforce. Job dissatisfaction among nurses may further reduce the strength of the nursing supply.

Current Nurse Shortage Is Due to Several Factors

Providers and experts around the country have reported that the nation is currently facing a shortage of nurses. There is a lack of comprehensive national data to describe the full nature and extent of the shortage, but several types of information point to an existing shortage. For example, California reported an RN vacancy rate of 8.5 percent for all employers in 1997, with hospitals reporting a rate of 9.6 percent, nursing homes 6.9 percent, and home health care 6.4 percent. The Dallas-Fort Worth Hospital Council reported vacancy rates for 2000 of 9.3 percent for RNs in emergency departments and 16.9 percent for RNs in critical care units. A recent survey of providers in Vermont found that nursing homes and home health care agencies had RN vacancy rates of 15.9 percent and 9.8 percent, respectively, while hospitals had an RN vacancy rate of 4.8 percent (up from 1.2 percent in 1996).

An important factor in the current shortage is the higher proportion of patients having more complex care needs, which increases the demand for nurses with training for specialty areas such as critical care and emergency departments. In addition, the increased use of technology in care settings has increased the demand for a higher skill mix of RNs. Furthermore, the expansion of care delivery settings—such as home health care and community-based health care delivery systems—has increased the job opportunities available and demand for these workers.

[4]42 U.S.C. Section 1395i-3 (e)(2)(A) and 42 U.S.C. Section 1396r(e)(2)(A).

A nursing shortage may have serious implications for the quality of patient care. A recent HRSA study found a relationship between higher RN staffing levels and the reduction of certain negative hospital inpatient outcomes, such as urinary tract infection and pneumonia.[5] Furthermore, a recent Health Care Financing Administration (HCFA) report to Congress found a direct relationship between nurse staffing levels in nursing homes and the quality of resident care. HCFA's analysis of three states' data demonstrated that, after controlling for case mix, there is a minimum nurse staffing threshold below which quality of care may be seriously impaired.[6] However, 23 percent of the facilities in the three states were not staffing at the combined RN and LPN minimum staffing threshold level, and 31 percent of the facilities were not staffing at the RN minimum staffing threshold level.[7]

The Nursing Shortage Is Likely to Worsen

The nursing shortage is expected to worsen in the future, with pressures expected on both demand and supply. The future demand for nurses is expected to increase dramatically when the baby boomers reach their 60s, 70s, and beyond. The population aged 65 years and older will double from 2000 to 2030. Moreover, the population aged 85 and older is the fastest growing age group in the U.S. At the same time, the number of persons who have traditionally worked in the nursing workforce—women between 25 and 54 years of age—is expected to remain relatively unchanged over the period from 2000 to 2030.[8] Over the past decade, the nurse workforce's average age has climbed steadily, while fewer young persons are choosing to enter the nursing profession. The average age of the RN population in 2000 was 45, almost 1 year older than the average in 1996. While over half (52 percent) of all RNs were reported to be under the age of 40 in 1980,

[5]Harvard School of Public Health, Vanderbilt University School of Nursing, and Abt Associates, *Nurse Staffing and Patient Outcomes in Hospitals*, contract No. 230-99-0021, HRSA (Washington, D.C.: HHS, 2001).

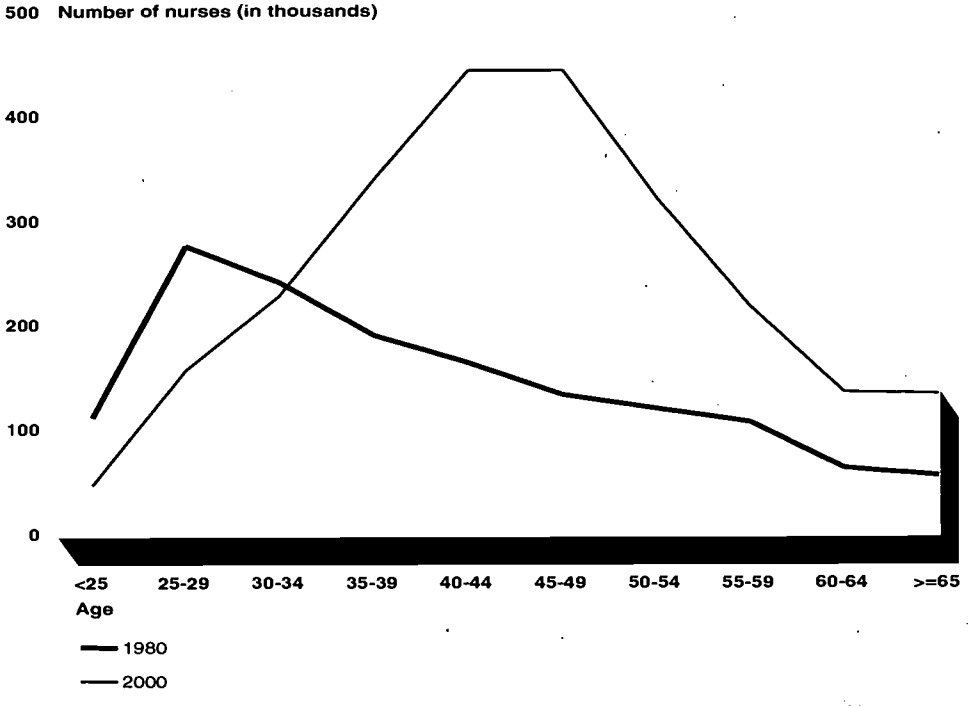
[6]The states included in the analysis were New York, Ohio, and Texas for calendar years 1996 and 1997. The minimum staffing threshold for RNs and LPNs combined was 0.75 hours per resident day. For RNs alone, the minimum staffing threshold level was 0.20 hours per resident day.

[7]Phase II of the HCFA Study is currently under way to analyze additional states' data to identify alternative minimum thresholds and optimal case-mix adjusters and to assess relative costs and benefits of such thresholds. According to HCFA officials, more research will be required to assess the feasibility of implementing minimum ratio requirements.

[8]Few men currently work in nursing. As of 2000, only 5.9 percent of RNs employed in nursing were men.

fewer than one in three were younger than 40 in 2000. During the same period, the percentage of nurses under age 30 dropped from 25 to 9 percent. As shown in figure 1, the age distribution of RNs has shifted dramatically upward. The number of nurses aged 25 to 29 decreased from about 296,000 in 1980 to about 177,000 in 2000, while the number aged 45 to 49 grew from about 153,000 to about 465,000.

Figure 1: Age Distribution of the Registered Nurse Population, 1980 and 2000



Source: HRSA, The Registered Nurse Population: National Sample Survey of Registered Nurses, March 2000.

The total number of licensed RNs increased 5.4 percent between 1996 and 2000—the lowest increase ever reported in HRSA's periodic survey of RNs.[9] Nursing program enrollments further indicate a narrowing of the

[9]HRSA, *The Registered Nurse Population: National Sample Survey of Registered Nurses*, Mar. 2000.

pipeline. According to a 1999 Nursing Executive Center Report, between 1993 and 1996, enrollment in diploma programs dropped 42 percent and enrollment in associate degree programs declined 11 percent.[10] Furthermore, between 1995 and 1998, enrollment in baccalaureate programs declined 19 percent, and enrollment in master's programs decreased 4 percent. Over the past 25 years, career opportunities available to women have expanded significantly, while there has been a corresponding decline of interest by women in nursing as a career. A recent study reported that women graduating from high school in the 1990s were 35 percent less likely to become RNs than women who graduated in the 1970s.[11]

In addition to the lack of students entering and graduating from nursing programs, there is concern about a pending shortage of nurse educators. The average age of professors in nursing programs is 52 years old, and 49 years old for associate professors. The average age of new doctoral recipients in nursing is 45, compared with 34 in all fields. From 1995 to 1999, enrollments in doctoral nursing programs were relatively stagnant.

Job Dissatisfaction May Be a Major Factor in Future Nurse Shortages

Job dissatisfaction may play a crucial role in determining the extent of future nurse shortages. Recent surveys of nurses have found decreased job satisfaction, and a high portion of respondents have reported increased pressure to accomplish work, the need to work overtime, and stress-related illness. A recent Federation of Nurses and Health Professionals survey found that half of the currently employed nurses who were surveyed had considered leaving the patient-care field for reasons other than retirement over the past 2 years.[12] Of this group, 56 percent indicated that they wanted a less stressful and physically demanding job, 22 percent said they were concerned about schedules and hours, and 18 percent wanted more money. Over one-fourth (28 percent) of nurses in a 1999 study by the Nursing Executive Center described themselves as somewhat

[10]The Nursing Executive Center, *A Misplaced Focus: Reexamining the Recruiting/Retention Trade-Off* (Washington, D.C.: The Advisory Board Company, Feb. 11, 1999).

[11]Buerhaus, Peter I. et al., "Policy Responses to an Aging Registered Nurse Workforce," *Nursing Economics* Vol. 18, No. 6 (Nov.-Dec. 2000).

[12]Federation of Nurses and Health Professionals, *The Nurse Shortage: Perspectives from Current Direct Care Nurses and Former Direct Care Nurses* (opinion research study conducted by Peter D. Hart Research Associates)(Washington, D.C.: 2001).

or very dissatisfied with their job, and about half (51 percent) were much less satisfied with their job than they were 2 years ago.[13]

Job dissatisfaction is a primary reason cited for nurse retention problems. As of March 2000, 18.3 percent of RNs reported not being employed in nursing, up slightly from 17.3 percent in 1992. A recent survey reported that the national turnover rate among hospital staff nurses was 15 percent, up from 12 percent in 1996.[14] Nursing home and home health care industry surveys indicate that nurse turnover is an issue for them as well. In 1997, a survey sponsored by the American Health Care Association (AHCA) of 13 nursing home chains identified a 51-percent turnover rate for RNs and LPNs.[15] A 2000 national survey of home health care agencies reported a 21-percent turnover rate for RNs and 24-percent turnover rate for LPNs.[16]

Demographic Changes, Low Compensation, and Difficult Working Conditions Contribute to Shortage of Nurse Aides

Demographic changes over the coming decades may also worsen the shortage of nurse aides. With the aging of the population, demand for nurse aides is expected to grow dramatically, while the number of persons who have traditionally filled these jobs will change very little. Retention of nurse aides is currently a significant problem for many hospitals, nursing homes, and home health care agencies, with some studies reporting annual turnover rates for aides working in nursing homes approaching 100 percent. Low wages, few benefits, and difficult working conditions contribute to recruitment and retention problems for nurse aides. High turnover can contribute to both increased costs to the facility and problems with quality of care.

Demographic Trends Will Continue to Increase Demand for Nurse Aides

Several factors have contributed to growing demand for nurse aides to provide health and long-term care services. In the decade between 1988 and 1998, the number of employed nurse aides increased 40 percent. Medical advances that have allowed people with chronic illnesses and

[13]The Nursing Executive Center, *The Nurse Perspective: Drivers of Nurse Job Satisfaction and Turnover* (Washington, D.C.: The Advisory Board Company, 2000).

[14] *The Nurse Perspective: Drivers of Nurse Job Satisfaction and Turnover.*

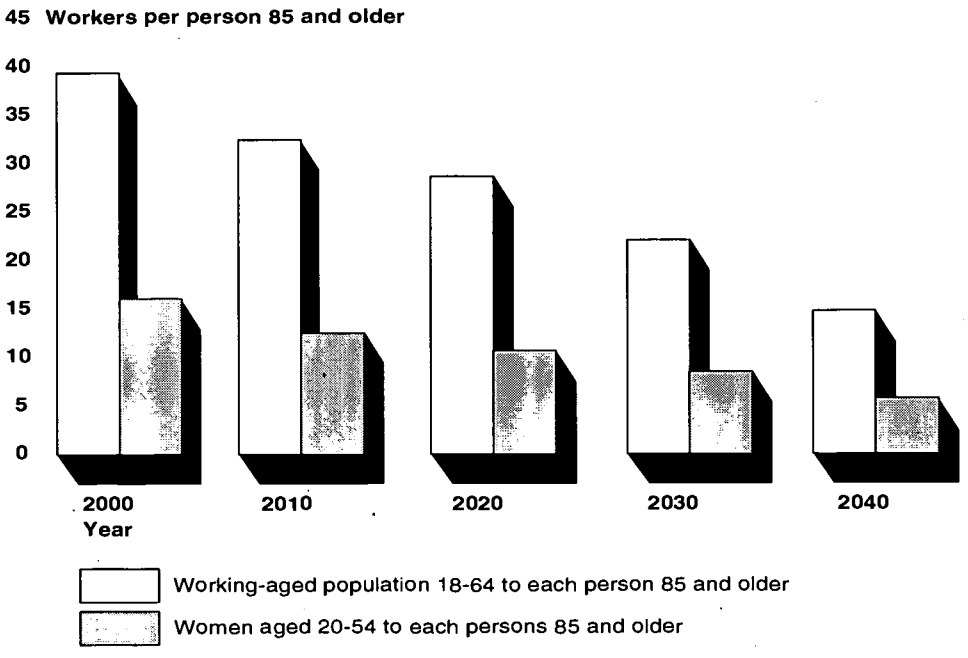
[15]American Health Care Association, *Facts and Trends 1999, The Nursing Facility Sourcebook* (Washington, D.C.: AHCA, 1999).

[16]Hospital & Healthcare Compensation Service, *Homecare Salary & Benefits Report, 2000-2001* (Oakland, N.J.: Hospital & Healthcare Compensation Service, 2000).

disabilities to live longer, advances in technology that have allowed people with significant care needs to receive care in their homes or other community-based settings, and increased funding for in-home services, particularly from the Medicare and Medicaid programs, are factors increasing demand for nurse aide services. In addition, the growing number of elderly will have a significant effect on demand in the future. The number of persons over age 85, those most in need of health and long term care services, will more than double from 4.3 million in 2000 to 8.9 million in 2030, when the baby boomers first begin to reach age 85.

At the same time, the supply of workers to fill these jobs will remain virtually unchanged. Between 2000 and 2030, the total working-age population—persons aged 18 to 64—is expected to grow by only 16 percent. The number of women aged 20 to 54—the traditional pool of nurse aides—will increase by only 9 percent from 2000 to 2030. The potential mismatch between future supply and demand for caregivers is illustrated by the change in the expected ratio of potential care providers to potential care recipients. As shown in figure 2, the ratio of the working-aged population, aged 18 to 64, to the population over age 85 will decline from 39.5 workers for each person 85 and older in 2000 to 22.1 in 2030 and 14.8 in 2040. The ratio of women aged 20 to 54 to the population age 85 and older will decline even more dramatically, from 16.1 in 2000 to 8.5 in 2030 and 5.7 in 2040.

Figure 2: Decline in Elderly Support Ratio Expected, 2000 to 2040



Source: GAO analysis of U.S. Census Bureau Projections of Total Resident Population, Middle Series, December 1999.

Over the next several years, even before the baby boomers begin retiring, nurse aide jobs are expected to be among the fastest growing in the workforce. The 40-percent increase in nurse aide employment from 1988 to 1998 is in contrast to the 19-percent increase in the number of persons employed in the overall labor market. From 1998 to 2008, the overall number of nurse aide jobs is projected to grow an additional 36 percent—from 2.1 million to 2.9 million jobs—compared to the 14-percent projected growth in all jobs. Jobs for nurse aides working in home health care are projected to increase even faster, namely by 58 percent, from 746,000 in 1998 to 1.2 million in 2008.

Recruitment and Retention of Nurse Aides Is Widely Reported To Be a Problem

Numerous reports and media accounts in recent years have described the inability of a range of providers to hire and retain adequate numbers of nurse aides. However, little analytical work has been conducted to assess the nature or overall magnitude of the paraprofessional nursing staff

shortage.[17] Nonetheless, the IOM and other experts agree that we are facing a shortage of nurse aides throughout the country.[18] The current low-unemployment economy has increased competition for workers and exacerbated the shortage of nurse aides. With a low national unemployment rate, higher paying jobs with better working conditions have opened up for women who have traditionally held nurse aide jobs.

Recent national analyses demonstrate the growing concern over the supply of these workers. In a 1999 survey of state long-term care ombudsmen, the respondents from more than 40 states reported "critical" shortages of direct care staff.[19] In another recent survey of states, officials from 42 of the 48 states responding reported that nurse aide recruitment and retention were currently major workforce issues in their states.[20] More than two-thirds of these states (30 of 42) reported that they were actively engaged in efforts to address these issues.

Several state or local level studies cite nurse aide recruitment as a problem for many providers. In a 2000 study of the nurse aide workforce in Pennsylvania, staff shortages were reported by three-fourths of nursing homes and more than half of all home health care agencies.[21] Over half (53 percent) of private nursing homes and 46 percent of certified home health care agencies reported staff vacancy rates higher than 10 percent. Nineteen percent of nursing homes and 25 percent of home health care agencies reported vacancy rates exceeding 20 percent. The Dallas-Ft. Worth Hospital Council reported a hospital vacancy rate for nurse aides of

[17]Some policymakers and planners have expressed concerns about the quality and timeliness of data currently available on these workers. HRSA is currently funding a project to assess trends, issues, and projections of supply and demand for nurse aides. It is expected that this work will be completed by late 2001 and will include identifying, comparing, and assessing the adequacy of existing data sources for assessing the scope and scale of current workforce shortages.

[18]Institute of Medicine, *Improving the Quality of Long-Term Care* (Washington, D.C.: National Academy Press, 2000).

[19]Submitted to the Domestic Strategy Group of the Aspen Institute by the Paraprofessional Healthcare Institute, *Direct-Care Health Workers: The Unnecessary Crisis in Long-Term Care* (Bronx, N.Y.: Paraprofessional Healthcare Institute, Sept. 2000).

[20]North Carolina Division of Facility Services, *Comparing State Efforts to Address the Recruitment and Retention of Nurse Aide and Other Paraprofessional Aide Workers* (Raleigh, N.C.: Sept. 1999).

[21]Leon, Joel et al., *Pennsylvania's Frontline Workers in Long Term Care* (Jenkintown, Pa.: Polisher Research Institute at the Philadelphia Geriatric Center, 2001).

17 percent in 2000, up from 11 percent in 1999. A recent survey of providers in Vermont found high vacancy rates for nurse aides, particularly in hospitals and nursing homes; as of June 2000, the vacancy rate for nurse aides in nursing homes was 16 percent, in hospitals 15 percent, and in home health care 8 percent.

Providers also face problems with retention of nurse aide staff. Available data indicate nurse aide turnover in nursing homes and home health care agencies is much higher than the labor force in general (13 to 18 percent) or the service workforce (20 percent).[22] Annual turnover rates among aides working in nursing homes are reported to be from about 40 percent to more than 100 percent. In 1998, a survey sponsored by AHCA of 12 nursing home chains found 94-percent turnover of nurse aide positions.[23] A recent national study of home health care agencies identified a 28-percent turnover rate among aides in 2000, up from 19 percent in 1994.[24]

Lower Wages, Fewer Benefits, and Difficult Work Conditions Linked to Nurse Aide Turnover

Studies have cited low wages and few benefits as factors contributing to nurse aide turnover. Our analysis of national wage and employment data from BLS indicates that, on average, nurse aides receive lower wages and have fewer benefits than workers generally; this is particularly true for those working in nursing homes and home health care.[25] In 1999, the national average hourly wage for aides working in nursing homes was $8.29, compared to $9.22 for service workers and $15.29 for all workers. For aides working in home health care agencies, the average hourly wage was $8.67, and for aides working in hospitals, $8.94. Aides working in

[22]Comprehensive national data on nurse aide turnover are not available, and caution must be used when comparing turnover rates from different studies. While nurse aide turnover rates are typically the number of nurse aides that have left a facility divided by the total number of nurse aide positions, there is no standard method for calculating turnover and methods used in different studies vary. It is generally agreed that staff who leave after a very short tenure on the job contribute most to high turnover rates. Some nurse aide positions may turn over several times during a given year, while others may not turn over for several years.

[23]AHCA, *Staffing of Nursing Services in Long Term Care: Present Issues and Prospects for the Future* (Washington, D.C.: AHCA, 2001).

[24]Hospital & Healthcare Compensation Service, *Homecare Salary & Benefits Report 2000-2001* (Oakland, N.J.: Hospital & Healthcare Compensation Service, 2000) and Hospital & Healthcare Compensation Service, *Homecare Salary & Benefits Report 1994-1995* (Oakland, N.J.: Hospital & Healthcare Compensation Service, 1994).

[25]Detailed demographic, employment, and wage data on nurse aides in hospitals, nursing homes, and home health care are presented in app. I.

hospitals are much more likely than aides in nursing homes and home health care to have employer-provided health and retirement benefits. Aides in nursing homes and home health care are similar to other service workers in that they are less likely to have employer-provided health insurance or pension coverage than workers in general. Most nursing homes and home health care agencies do not offer pension coverage, and only 21 to 25 percent of aides in these settings are covered.

Our analysis of CPS data indicates that many nurse aides have sufficiently low earnings and family incomes to qualify for public benefits such as food stamps and Medicaid. While 11 percent of all workers had family incomes below poverty, 18 percent of aides working in nursing homes and 19 percent of aides working in home health care had incomes below that level. One in three aides working in nursing homes earned less than $10,000 per year, and 36 percent reported family incomes below $20,000. In addition, aides working in nursing homes and home health care are more than twice as likely as other workers to be receiving food stamps and Medicaid, and they are much more likely to lack health insurance. One-fourth of aides in nursing homes and one-third of aides in home health care are uninsured compared to 16 percent of all workers.

Studies have also identified the physical demands of nurse aide work and other aspects of the workplace environment as contributing to retention problems. Nurse aide jobs are physically demanding, often requiring moving patients in and out of bed, long hours of standing and walking, and dealing with patients or residents who may be disoriented or uncooperative. Nursing homes have one of the highest rates of workplace injury, 13 per 100 employees in 1999, compared to the construction industry with 8 per 100 employees.

The 2000 IOM study of quality in long-term care identified several environmental and job design factors that directly affect nurse aide turnover, including

- adequacy of training;
- methods for managing workload and schedules;
- opportunities for career advancement;
- respect from administrators;
- organizational recognition;
- workloads and staffing levels;
- clarity of roles; and
- participation in decisionmaking.

In another study, the degree of nurse aide involvement in resident care planning was superseded only by the condition of the local economy as a factor affecting turnover.[26] For example, in facilities where nursing staff were perceived to accept aides' advice and suggestions or simply discussed care plans with aides, the turnover was lower than in those facilities where aides were not involved in care planning.

High Nurse Aide Turnover May Lead to Higher Provider Costs and Quality of Care Problems

Negative effects—related to both costs for the facility and quality of patient care—have been associated with high turnover. Direct provider costs of turnover include recruitment, selection, and training of new staff, overtime, and use of temporary agency staff to fill gaps. Indirect costs associated with turnover include an initial reduction in the efficiency of new staff and a decrease in nurse aide morale and group productivity.

High turnover can disrupt the continuity of patient care—that is, aides may lack experience and knowledge of individual residents or clients. Furthermore, when turnover leads to staff shortages, nursing home residents may suffer harm because of the increased number of residents the remaining staff must care for, resulting in less time to care for each resident. The recent HCFA report to Congress that found a direct relationship between nurse staffing levels in nursing homes and quality also found a direct relationship between nurse aide staffing levels and the quality of resident care. HCFA's analysis of the three states' data demonstrated that, after controlling for case mix, there is a minimum nurse aide staffing threshold below which quality of care may be seriously impaired.[27] Moreover, 54 percent of the facilities in the three states were not staffing at that minimum threshold level.[28]

[26]Banaszak-Holl, Jane and Marilyn A. Hines, "Factors Associated with Nursing Home Staff Turnover", *The Gerontologist*, Vol. 36, No. 4 (1996), pp. 512-17.

[27]The states included in the analysis were New York, Ohio, and Texas for calendar years 1996 and 1997.

[28]Nurse aides had a minimum staffing level of 2.00 hours per resident day.

Government and Private Initiatives Seek to Address Nurse Aide Retention and Recruitment, but Few Have Been Evaluated

Most initiatives and research efforts to address nurse aide recruitment and retention have been undertaken by states and provider groups. In 1999, 30 states indicated that they were addressing nurse aide recruitment and retention, primarily in nursing homes and home health care agencies, through task forces, initiatives, and research. HHS has also recently begun to focus on the supply and demand of this workforce through research and planning efforts. (See appendix II.)

Initiatives intended to improve nurse aide recruitment and retention can be categorized under three major themes: (1) improved wages and benefits; (2) the development of additional training and opportunities for career advancement; and (3) additional employee supports, including improved work environments, job skills, and social supports. In addition, many initiatives are multifaceted, addressing two or more of these areas. The programs discussed below illustrate the types of initiatives under way. Appendix II provides additional information on selected initiatives.

States have taken steps to improve the wages or benefits of nurse aides by increasing reimbursement rates, primarily for aides working in nursing homes and home health care. As of 2000, 26 states had established some form of a wage pass-through, wage supplement, or related program for nurse aides and other direct care staff.[29] Methods of wage pass-throughs vary from state to state; participation by providers can be voluntary or mandatory, and states use different formulas to calculate the amount of money provided. According to the 2000 North Carolina Division of Facility Services survey, 4 out of 12 states that had implemented a wage pass-through reported that it had had some positive effect on recruitment and retention of nurse aides, although little data exist to substantiate this view. While some states have reported that they are satisfied with their accountability procedures to ensure that pass-through dollars are reaching

[29]North Carolina Division of Facility Services, *Results of a Follow-Up Survey to States on Wage Supplements for Medicaid and Other Public Funding To Address Aide Recruitment and Retention In Long-term Care Settings* (Raleigh, N.C.: Nov. 4, 2000) and *Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives* (GAO/HEHS-00-197, 2000). Wage pass-throughs provide a specific amount or percentage increase in reimbursement, earmarked typically for nurse aides' salaries and/or benefits.

aides, concerns have been raised that funds may not always be used as intended. Few states have addressed the issue of benefits for nurse aides. According to a 1999 study, only three states had considered or taken action to require any form of benefits for nurse aides and other workers.[30]

Initiatives to improve training and opportunities for career advancement have been undertaken by states as well as providers. States and providers are experimenting with specialized training for nurse aides in targeted patient care areas, such as treatment of persons with dementia, and are developing career ladders that offer aides a chance to improve their skills while also advancing their careers. For example, according to Massachusetts officials, the Massachusetts' Nursing Home Quality Initiative provides $5 million in fiscal year 2001 specifically to develop competitive nurse aide career ladder grants and to encourage the development of partnerships of concerned groups, including community colleges and workforce investment boards.[31]

Initiatives that focus on workplace and social supports for nurse aides fall into two categories. The first type of support targets the structure of the aides' work environment, focusing on issues such as nurse aide participation in care planning and the empowerment of nurse aides to act on their special knowledge of their clients. For example, the Wellspring Program in Wisconsin is an alliance of 11 providers whose approach is based on the idea that management should foster quality of care with appropriate policies, but decisions on policy implementation should be left to the front-line workers who are most familiar with residents' needs.

The second type of support focuses on general work skills and social supports for nurse aides. For example, the Iowa Caregivers Association, a nonprofit organization representing nurse aides, received state funding to develop a pilot project to determine the effect on nurse aide recruitment and retention of employee supports such as workshops on teamwork and

[30]The states identified in the study were Hawaii, Idaho, and Maine. See North Carolina Division of Facility Services, *Comparing State Efforts to Address the Recruitment and Retention of Nurse Aide and Other Paraprofessional Aide Workers* (Raleigh, N.C.: Sept. 1999).

[31]The federal Workforce Investment Act of 1998 required states and localities to develop workforce investment boards. The state board works with the governor to develop a statewide workforce development plan and helps develop statewide workforce investment systems and labor market information systems. Local boards are responsible for implementing the system in their local area.

communication and an aide-mentoring program. Additionally, the California Caregivers Training Initiative is a state-funded effort to improve nurse aide recruitment and retention and includes providing supportive services such as childcare and transportation. Other state and provider initiatives have addressed general work skills through programs such as general educational development diploma preparation or courses in English as a Second Language.

HRSA's Division of Nursing is charged with providing national leadership to ensure an adequate supply and distribution of qualified nursing professionals. HRSA has generally focused on licensed nursing professionals, rather than nurse aides, but has recently undertaken a study of the supply of and demand for aides. Along with HRSA, HCFA and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) are also focusing attention on the nurse aide workforce. HCFA plans to address issues that affect nurse aide recruitment and retention in Phase II of the Report to Congress on Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, while ASPE's research is designed to identify successful recruitment and retention programs for nurse aides.

To date, most research on initiatives to address the nurse aide shortage has been largely nonevaluative. Providers cite reduced turnover rates as evidence of effectiveness. Some efforts are now under way to determine the effectiveness of various interventions. Two states, Kansas and Michigan, have gathered longitudinal data on the impact of their wage pass-throughs on turnover. Michigan's data indicate that since the implementation of the nursing home wage pass-through in 1990, turnover rates have decreased from 75 percent to 68 percent, while in Kansas turnover has declined slightly, from 120 percent to 116 percent, since implementation in 1998, but these measures may not account for other factors that affect the aide workforce. Some states and providers have also begun to realize the importance of formal evaluations and have implemented evaluation efforts as a component of their initiatives. Further information on these and other evaluations is included in appendix II.

Concluding Observations

Recruitment and retention of nursing staff—both nurses and nurse aides—pose a problem today that will likely worsen as demand for these workers increases in the future. Demographic forces are widening the gap between the numbers of people needing care and the nursing staff available to provide care. As a result, the nation will face a shortage of different dimensions than those of the past. The private sector and state governments have taken the lead in trying to address recruitment and

retention issues for nurse aides. Additional evaluation is needed to determine which initiatives are most effective. More detailed data are also needed to delineate the extent and nature of nurse and nurse aide shortages to assist in planning and targeting corrective efforts. As the federal government focuses more on the nursing workforce in hospitals, nursing homes, and home health care, support for the evaluation of efforts to increase the supply of nurses and nurse aides may also help identify more effective steps to ameliorate the shortage.

Chairman Jeffords and Ranking Member Kennedy, this concludes my statement. I would be happy to answer any questions that you or Members of the Committee may have.

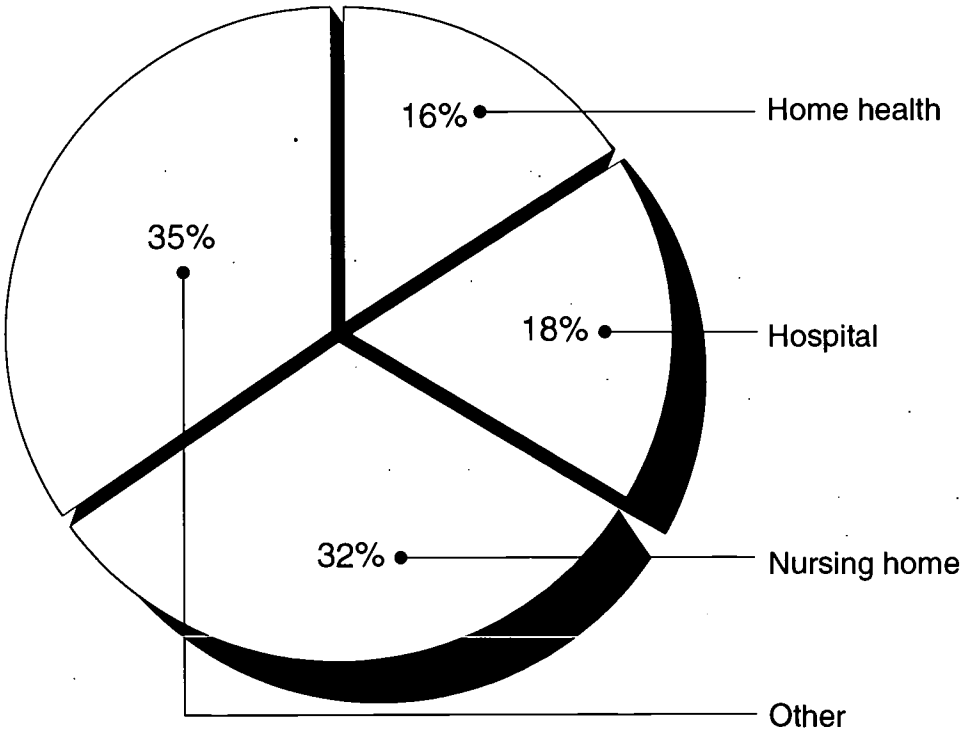
GAO Contacts and Staff Acknowledgments

For more information regarding this testimony, please contact me or Janet Heinrich at (202) 512-7118, or Helene Toiv at (202) 512-7162. Eric Anderson, Connie Peebles Barrow, Paula Bonin, Emily Gamble Gardiner, and Nila Garces-Osorio also made key contributions to this statement

Appendix I: Demographic and Employment Characteristics of Nurse Aides

Nurse aides work for a variety of employer types and in a variety of settings. Of the approximately 2.2 million nurse aides employed in 1999, most work either in nursing homes, hospitals, or home health care. (See fig. 3.) Nurse aides compose a much smaller percentage of total employees in hospitals than they do in either nursing homes or home health care. (See fig. 4.) In contrast, nurses make up the largest portion of hospital employees, and a smaller share of workers in nursing homes and home health care.

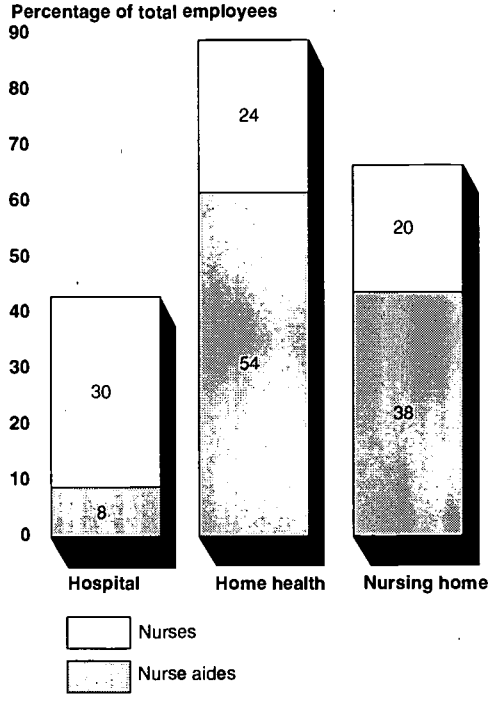
Figure 3: Nurse Aide Employment by Setting, 1999



Note: "Other" includes a range of employment settings such as residential care, social services, and temporary staffing agencies.

Source: GAO analysis of Bureau of Labor Statistics, 1999 Occupational Employment Statistics data.

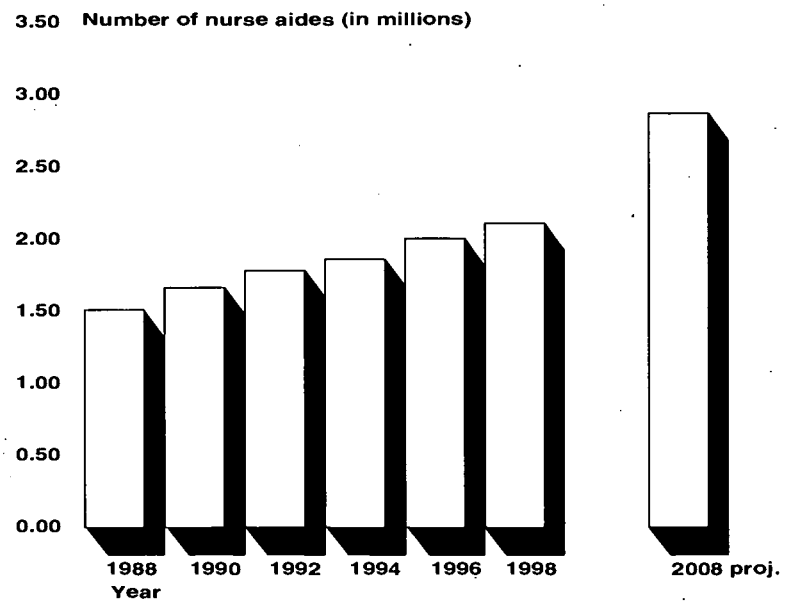
Figure 4: Nurses and Nurse Aides as a Percentage of all Employees in Hospitals, Home health care, and Nursing homes, 1999



Source: GAO analysis of Bureau of Labor Statistics, 1999 Occupational Employment Statistics data.

The number of nurse aides in the workforce increased by 40 percent between 1988 and 1998 (see fig. 5), more than twice the rate of growth of the overall workforce. The greatest growth was among aides working in home care, with their numbers more than doubling from 1988 to 1998. According to BLS projections, these trends are expected to continue into the next decade. While total employment in the workforce is projected to grow by 14 percent from 1998 to 2008, projections for nurse aide employment call for a 36-percent increase over the period, and a 58-percent increase in the numbers working in home care.

Figure 5: Growth in Nurse Aide Employment, 1988-1998 and Projected to 2008



Source: Bureau of Labor Statistics, Monthly Labor Review.

Compared to the workforce in general, nurse aides are more likely to be female, non-white, unmarried, and with children at home. (See table 2.) While half of all workers and about two-thirds of service workers are women, 80 to 90 percent of nurse aides are women. In addition, nurse aides tend to be somewhat younger than the overall workforce, and a high proportion are minorities. About half of nurse aides are non-white, compared to only one-quarter of all workers. Aides in hospitals have slightly higher rates of employer-provided health and pension benefits than the general workforce. However, aides in nursing homes and home health care are less likely than other workers to have employer-provided health insurance and much less likely to be covered by a pension.

Table 2: Characteristics of Nurse Aides and Other Workers

	Nurse Aides working in				
	Nursing homes	Home health care	Hospitals	Service workers	All workers
Mean age	37.0	41.3	38.7	37.3	44.8
Age ranges (percent)					
<25	21.3	11.8	13.4	23.7	13.0
25-34	26.8	20.4	27.2	22.7	19.3
35-44	24.7	29.0	27.9	24.0	22.4
45-54	15.1	21.2	17.4	16.2	17.7
55+	12.2	17.8	14.1	13.3	27.6
Gender (percent)					
Male	9.1	10.8	20.4	32.5	48.0
Female	90.9	89.2	79.6	67.5	52.0
Race/Ethnicity (percent)					
White, non-Hispanic	56.6	48.5	53.5	60.3	73.8
Black, non-Hispanic	31.8	33.8	33.0	18.1	11.5
Hispanic and other	11.5	17.6	13.5	21.6	14.7
Immigration (percent)					
Native born	88.9	79.6	86.9	80.9	87.8
Immigrant	11.1	20.4	13.1	19.1	12.3
Education					
Less than high school	22.6	21.4	10.1	24.8	17.4
High school	50.0	40.7	43.8	42.3	33.1
Some college	27.3	37.9	46.2	32.8	49.5
Marital Status (percent)					
Married	39.4	43.5	43.7	43.7	57.2
Never married	36.8	26.9	32.6	37.3	23.8
Widowed, divorced or separated	23.8	29.5	23.7	19.0	19.0
Children (percent)					
None	43.7	49.9	54.8	53.9	61.8
Any under 18 years	56.3	51.1	45.2	46.1	38.2
Unmarried with children (percent)	32.4	24.6	20.2	20.8	11.0

Source: GAO analysis of combined 1998, 1999, and 2000 Current Population Survey, March Supplements.

Many nurse aides are among the working poor. Aides working in nursing homes and home care are much more likely than other workers to be uninsured, living below the poverty level, and receiving public benefits such as food stamps and Medicaid. (See table 3.) Nursing home and home health care aides are also two to three times more likely as other workers to be unmarried and have children at home. Among single parent nursing home and home health care aides, 35 to 40 percent are below poverty, and 30 to 35 percent receive food stamps.

Table 3: Income, Earnings, and Poverty Status of Nurse Aides and Other Workers

	Nurse Aides working in				
	Nursing homes	Home health care	Hospitals	Service workers	All workers
Family income (percent)					
Under $10,000	12.4	16.1	6.8	13.0	9.3
$10,000-19,999	23.8	21.6	16.7	19.7	13.3
$20,000-29,999	18.2	19.6	16.9	15.9	12.9
$30,000-39,000	14.6	13.2	14.9	12.7	11.7
$40,000-49,999	11.3	9.5	11.6	10.1	10.0
$50,000 +	19.7	20.0	33.2	28.5	42.8
Family income					
Mean	$33,982	$33,653	$43,832	$40,712	$56,020
Median	26,970	25,908	36,080	30,769	42,400
Individual earnings					
Mean	$14,723	$13,501	$17,834	$13,412	$22,313
Median	13,287	12,265	16,608	10,795	13,500
Individual earnings (full-time, full-year workers)					
Mean	$19,416	$19,216	$21,432	$19,515	$39,672
Median	17,000	17,002	20,000	16,608	30,663
Poverty status (percent)					
Below poverty	17.8	18.8	8.1	16.1	10.5
100 –149	13.2	15.9	10.4	12.8	8.4
150 –199	15.0	11.4	11.9	12.6	8.9
Above 200	54.1	53.9	69.6	58.4	72.3
Health insurance (percent)					
Uninsured	25.2	32.1	14.2	31.2	16.4
Employer coverage	57.5	47.3	77.9	51.7	61.6
Medicaid	9.9	11.1	2.1	6.9	3.9
Pension coverage					
Percent covered	25.2	21.2	51.3	21.3	44.4
Food stamps					
Percent receiving	13.5	14.8	5.3	9.3	5.5

Note: All reported income and earnings have been adjusted to constant 1999 dollars using the Consumer Price Index, U.S. city average, for all urban consumers.

Source: GAO analysis of combined 1998, 1999, and 2000 Current Population Survey, March Supplements.

Nationally, the mean hourly wage for a nurse aide in all settings was $8.59 in 1999, yet wages vary widely across states. (See table 4.) The competitiveness of nurse aide wages with those of other service or production jobs where they might be likely to find employment also varies widely across states, as does the relative economic standing of nurse aides compared to other workers. As a percentage of state per capita income, the mean annual earnings of a nurse aide in 1999 ranged from a high of 85 percent in Alaska to a low of 48 percent in the District of Columbia. (See table 5.)

Table 4: Nurse Aide Wages Compared to Other Occupations, by State, 1999

	Mean hourly wage, 1999			
	Nurse aide[a]	Factory worker[b]	Fast food cook	Housekeeper
Alabama	$7.24	$10.45	$5.90	$6.35
Alaska	11.63	11.12	9.05	9.09
Arizona	8.26	9.85	6.39	6.66
Arkansas	6.78	8.98	6.09	6.30
California	8.93	10.18	6.86	7.82
Colorado	8.56	9.67	6.40	7.42
Connecticut	11.32	12.36	7.14	8.69
Delaware	9.01	9.37	6.81	7.45
District of Columbia	9.29	[c]	7.54	10.33
Florida	8.25	8.82	6.90	7.07
Georgia	7.40	10.03	6.56	6.80
Hawaii	9.57	9.94	7.60	10.96
Idaho	7.71	9.61	6.40	6.67
Illinois	8.16	12.64	6.74	7.29
Indiana	8.22	11.06	6.59	7.01
Iowa	8.17	11.71	6.65	7.07
Kansas	7.86	10.51	6.70	6.82
Kentucky	7.77	11.40	6.25	6.80
Louisiana	6.53	10.40	5.96	6.32
Maine	8.01	9.43	6.78	7.61
Maryland	8.98	11.60	6.50	7.85
Massachusetts	9.96	11.13	7.71	8.45
Michigan	8.76	12.43	6.55	7.59
Minnesota	9.27	11.21	6.82	8.05
Mississippi	7.19	9.20	6.32	6.46
Missouri	7.45	12.08	6.35	6.88
Montana	7.47	10.18	5.93	6.45
Nebraska	8.37	10.24	7.02	6.96
Nevada	9.66	10.07	6.62	8.66
New Hampshire	9.32	10.43	7.21	7.71

	Mean hourly wage, 1999			
	Nurse aide[a]	Factory worker[b]	Fast food cook	Housekeeper
New Jersey	9.85	11.17	6.83	7.98
New Mexico	7.35	9.57	6.09	6.69
New York	9.27	10.26	6.69	9.71
North Carolina	7.77	10.45	6.38	7.06
North Dakota	7.48	9.38	6.40	6.56
Ohio	8.34	11.11	6.52	7.27
Oklahoma	7.17	11.91	6.08	6.53
Oregon	8.58	10.44	7.23	7.68
Pennsylvania	8.82	10.82	6.34	7.66
Rhode Island	9.51	8.78	6.84	8.28
South Carolina	7.54	11.66	6.39	6.93
South Dakota	7.66	8.74	6.42	6.60
Tennessee	7.77	10.18	6.53	6.79
Texas	8.63	9.19	6.24	6.40
Utah	8.10	9.11	6.70	7.08
Vermont	8.30	10.24	7.52	7.42
Virginia	7.67	10.19	6.26	7.05
Washington	8.59	11.13	6.74	7.87
West Virginia	6.83	8.60	5.99	6.57
Wisconsin	8.66	10.56	6.59	7.37
Wyoming	7.74	8.95	6.34	7.09
U.S.	8.59	10.67	6.54	7.46

[a]Wage data for nurse aides represent the combined total of workers in three OES occupational categories: (1) nursing aides, orderlies, and attendants; (2) home health care aides; and (3) personal and home care aides.

[b]Factory workers consist of the occupational category "team assemblers," persons who work as part of a team having responsibility for assembling an entire product or component of a product. Team assemblers compose the largest single category of production worker, accounting for just over 10 percent of all production employees.

[c]Wage data for factory workers in the District of Columbia were not available.

Source: GAO analysis of Bureau of Labor Statistics, 1999 Occupational Employment Statistics data.

Table 5: Nurse Aide Earnings as a Percentage of State Per Capita Income, 1999

State	Mean annual earnings[a]	Per capita income	Aide earnings as percentage of state per capita income
Alabama	$15,068	$22,987	66
Alaska	24,199	28,577	85
Arizona	17,185	25,189	68
Arkansas	14,101	22,244	63
California	18,569	29,910	62
Colorado	17,811	31,546	56
Connecticut	23,544	39,300	60
Delaware	18,750	30,778	61
District of Columbia	19,323	39,858	48
Florida	17,154	27,780	62
Georgia	15,383	27,340	56
Hawaii	19,898	27,544	72
Idaho	16,028	22,835	70
Illinois	16,967	31,145	54
Indiana	17,105	26,143	65
Iowa	16,986	25,615	66
Kansas	16,355	26,824	61
Kentucky	16,164	23,237	70
Louisiana	13,592	22,847	59
Maine	16,655	24,603	68
Maryland	18,685	32,465	58
Massachusetts	20,715	35,551	58
Michigan	18,216	28,113	65
Minnesota	19,286	30,793	63
Mississippi	14,945	20,688	72
Missouri	15,501	26,376	59
Montana	15,537	22,019	71
Nebraska	17,401	27,049	64
Nevada	20,094	31,022	65
New Hampshire	19,377	31,114	62
New Jersey	20,481	35,551	58
New Mexico	15,289	21,853	70
New York	19,279	33,890	57
North Carolina	16,172	26,003	62
North Dakota	15,553	23,313	67
Ohio	17,348	27,152	64
Oklahoma	14,921	22,953	65
Oregon	17,850	27,023	66
Pennsylvania	18,339	28,605	64
Rhode Island	19,788	29,377	67
South Carolina	15,681	23,545	67

State	Mean annual earnings[a]	Per capita income	Aide earnings as percentage of state per capita income
South Dakota	15,923	25,045	64
Tennessee	16,153	25,574	63
Texas	17,961	26,858	67
Utah	16,852	23,288	72
Vermont	17,260	25,889	67
Virginia	15,954	29,789	54
Washington	17,877	30,392	59
West Virginia	14,204	20,966	68
Wisconsin	18,022	27,390	66
Wyoming	16,105	26,396	61
U.S.	17,866	28,542	63

[a]Mean annual earnings are for a full-time, full-year worker (2,080 hours) earning the mean hourly wage. Sixty-seven percent of all workers are employed full-time for the full year compared to 68 percent of hospital aides, 60 percent of aides in nursing homes, and 53 percent of aides in home health care.

Source: GAO analysis based on earnings data from Bureau of Labor Statistics, 1999 Occupational Employment Statistics data and per capita income data from the Bureau of Economic Analysis, U.S. Department of Commerce.

Technical Notes on Analysis

Two primary sources of data were used to describe the demographic and employment characteristics of nurse aides—the Current Population Survey (CPS) conducted by the Census Bureau for the Bureau of Labor Statistics (BLS) and the Occupational Employment Statistics (OES) survey conducted by BLS and State Employment Security Agencies.

The CPS is a monthly survey of approximately 47,000 households and is the source of official government statistics on employment and unemployment. The monthly CPS contains basic demographic and labor force data, while the March CPS survey contains additional data on work experience, income, benefits, and migration. For our analysis, we used the March CPS files. Although the overall sample size of the monthly CPS is large, nurse aides represent a relatively small portion of the overall workforce. In order to obtain a sample of aides large enough to support our statistical analysis, we combined the 3 most recent years of data from the March CPS in 1998, 1999, and 2000. We ended with a weighted sample of 766 hospital aides, 1,230 nursing home aides, and 1,073 home health care aides.

Paraprofessional nursing aide workers may be classified under several occupational and industry categories in the CPS. We selected two occupational categories: health aides, except nursing (occupational code 446) and nursing aides, orderlies, and attendants (code 447). We cross-

tabulated these two occupational codes (446, 447) by industry codes to identify the settings where these workers are employed. We included hospitals (industry code 831) and nursing and personal care facilities (code 832). We identified nurse aides working in home health care as those employed in private households (code 761), social services (code 871), and health services, not elsewhere classified (code 840). We considered service workers to be those classified in private household occupations (codes 403-407) and service occupations (codes 433-469) regardless of industry.

The OES program surveys approximately 400,000 establishments per year, taking 3 years to fully collect the sample of 1.2 million establishments. The OES collects data on wage and salary workers in nonfarm establishments and produces employment and wage estimates for over 700 occupations by geographic area and by industry. Employment and wage data for nurse aides were based on three occupational categories in the OES: (1) nursing aides, orderlies, and attendants (standard occupational code 31-1012), (2) home health care aides (31-1011), and (3) personal and home care aides (39-9021). We compared data across three employment settings: hospitals (standard industry code 806), nursing and personal care facilities (805), and home health care services (808). For comparison purposes we chose three other occupational categories: team assemblers (51-2092), fast food cooks (35-2011), and maids and housekeeping cleaners (37-2012).

Appendix II: Examples of Government and Private Initiatives to Address Nurse Aide Recruitment and Retention

Initiatives and research efforts to address nurse aide recruitment and retention focus primarily on improved wages and benefits (table 6), opportunities for additional training and career advancement (table 7), and additional employee supports, including improved work environments, job skills, and social supports (table 8). Many initiatives are also multifaceted, addressing two or more of these areas (table 9). While states and providers have undertaken most initiatives and research efforts, the federal government has recently begun to focus on the supply and demand of this workforce. The Department of Health and Human Services, through HRSA, HCFA, and ASPE, has undertaken research and planning efforts focused on nurse aide issues (table 10). The tables describe selected examples of initiatives and research efforts, and are not meant to be comprehensive.

Table 6: Wages and Benefits

	State wage pass-throughs
Affected provider type	Nursing homes and home health care agencies
Description	States with wage pass-throughs require that some portion of a long-term care reimbursement increase from a public funding source be used specifically to increase wages and/or benefits for nurse aides. In some states, only facilities that apply may participate in the pass-through programs. As of September 2000, 26 states have established a wage pass-through, wage supplement, or related program to provide supplemental wages or benefits.
Funding source	Varies (funds are usually from Medicaid, but may also include Older Americans Act funds, state appropriations, and other sources)
Start date	Varies from state to state. Some states have had pass-throughs in place since the early 1980s to deal with episodic worker shortages; most pass-throughs are relatively recent.
Evaluation findings	Data collected in Michigan indicate that between 1990 and 1998, the aide turnover rate dropped from 74.5 percent to 67.45 percent, which the state attributes to a pass-through that has been in place since 1990.Kansas' aide turnover rate in facilities participating in the 1999 pass-through went from 120 percent in 1998 to 116 percent in 1999. There have been no evaluations examining short- or long-term effects of the wage pass-through strategy and differences in outcomes based on state variations in methodology.

Table 7: Training and Career Ladders

	Massachusetts Nursing Home Quality Initiative
Affected provider type	Nursing homes (other provider types may be included in one component of the initiative, provided a nursing home is the primary applicant)
Description	The initiative grants state funds to providers, and includes $35 million for a wage pass-through for nurse aides, $1 million for a scholarship program to attract new aides, $5 million for a career ladder grant program for aides, and $1.1 million in education and job supports for current or former welfare recipients interested in a career as a nurse aide. The career ladder grant program includes a component targeting the culture of nursing homes; this component also requires applicants to collaborate with other providers, the workforce development community, community colleges, and other interested groups to increase program impact.
Funding source	Funded by a $42 million appropriation from the state.
Start date	Implemented in 2000.
Evaluation findings	No evaluation has been conducted to date. Grantees in the career ladder program are required to participate in an evaluation that will be conducted by The Commonwealth Corporation. The scheduled deadline for this evaluation is June 30, 2002.

	Virginia Nursing Assistant Institute Initiative
Affected provider type	Nursing homes, home health care agencies, hospitals
Description	The Institute was developed by local officials, associations, and providers to offer comprehensive free or low-cost aide training; conduct workforce needs assessments; provide technical assistance to providers interested in promoting best practices management; facilitate aide recruitment; provide networking and peer support; and increase community awareness of the aide shortage. The initiative is a joint effort of seven agencies in the western Virginia area.a
Funding source	Private funds, private and public grants
Start date	1999
Evaluation findings	No overall evaluation conducted to date.

[a]The agencies are Charlottesville Albemarle Technical Education Center, the Jefferson Area Board for the Aging, Monticello Area Community Action Agency, Martha Jefferson Hospital, Piedmont Virginia Community College, University of Virginia Health Systems, and Williamson's Health Care Network.

Table 8: Employee Supports

	The Wellspring Program
Affected provider type	Nursing homes
Description	The Wellspring Program is a collaborative of 11 providers and is based on the idea that while top levels of management should create quality of care through appropriate policy, decisions on how to implement the policy should be made by the front-line workers who are most familiar with the needs of the residents. To implement this policy, the facilities who compose the Wellspring Program have created "care resource teams" which receive specialized job training and are empowered to train other workers and develop, implement, and evaluate facility level care and structural changes. Nurse aides play a prominent role in these interdisciplinary teams. Additionally, clinical experts, including a geriatric nurse consultant, are available to the teams, and the geriatric nurse consultants regularly visit each facility to provide assistance and support.
Funding source	Private
Start date	1994
Evaluation findings	The Institute for the Future of Aging Services, with funding from The Commonwealth Fund, is conducting an evaluation of the Wellspring Program. However, turnover rates for aides across the 11 facilities have dropped from 110 percent (1994) before the implementation of the Wellspring Program to a current rate of 23 percent (2001).

	California Caregivers Training Initiative
Affected provider type	Nursing homes, home health care agencies, hospitals
Description	The state of California's Caregiver Training Initiative (CTI) is designed to develop and implement proposals to recruit, train, and retain caregivers, including nurse aides and other entry level staff. Initiatives undertaken with funds from CTI must be regional in scope and may include supportive services such as childcare, transportation, and personal growth workshops. Participants in the regional initiatives must meet the eligibility requirements of the two funding sources, the federal Workforce Investment Act and Welfare to Work Grant Program state matching funds. In order to receive money from CTI, applicants must develop collaborations with representatives of the health care industry, public agencies, labor organizations, and public education. As of January 31, 2001, 12 grants, ranging in size from $400,000 to just over $2.5 million, were awarded.
Funding source	$25 million ($15 million from Workforce Investment Act funds, and $10 million from State General Fund match dollars)
Start date	2000
Evaluation findings	No evaluation has been conducted to date. However, an evaluation is required . The evaluation will address the implementation, process, and outcomes of each funded program. Programs are required to collect and maintain data on an ongoing basis, and to provide regular progress reports to the evaluation staff.

	Iowa Caregivers Association CNA Recruitment and Retention Pilot Project
Affected provider type	Nursing homes
Description	The goal of the CNA Recruitment and Retention Pilot Project was to assess and address the needs of direct care workers in order to reduce staff turnover in nursing facilities. After conducting a needs assessment of nurse aides in the state, the Iowa Caregivers Association recruited three facilities to participate in the pilot as tracking facilities and three to act as control facilities (with two additional urban facilities recruited during the second year of the pilot). They then implemented a series of interventions, including training on conflict resolution, workshops in communication and team building, and a nurse aide mentoring training program.
Funding source	Funded through the Iowa Department of Human Services
Start date	1998
Evaluation findings	An evaluation by the National Resource Center for Family Centered Practices at the University of Iowa School of Social Work found that the average length of service over the 2-year pilot period was 18.96 months in the intervention facilities versus 10.01 months in the control facilities. Significantly lower turnover rates occurred in the treatment facilities than in the control facilities (34 percent vs. 82 percent) in the first year. Additionally, treatment facilities scored significantly better than control facilities on several indicators of job satisfaction.

Table 9: Multifaceted

	Cooperative Home Care Associates
Affected provider type	Home health care agencies
Description	Cooperative Home Care Associates (CHCA) is a worker-owned home health care provider in the Bronx, New York. It currently employs 550 minority women, and was developed on the premise that home health care clients would receive higher quality of care if home health care workers were offered higher quality jobs. Over 75 percent of women who work for CHCA were previously dependent on public assistance. Wages at CHCA are among the area's highest, and the provider offers a full range of benefits, including health care and a retirement plan. CHCA provides 4 weeks of classroom training plus 90-days of on-the-job training, and offers continuing development to staff. Employees are given the opportunity to become owners of the company, and senior staff are also guaranteed a minimum of 30 hours per week.
Funding source	Private
Start date	1985
Evaluation findings	No formal evaluation has been conducted. However, CHCA reports that its annual turnover of aides is less than 25 percent, and within the last 2 years 82 percent of aides remained with CHCA at least 180 days.

	Providence Mount Saint Vincent
Affected provider type	Nursing home
Description	Providence Mount Saint Vincent (PMSV) is a long-term care facility in Seattle, Washington that offers a range of services, including a nursing center and adult day services. In 1991, PMSV restructured itself to provide "resident directed care." The organization defines resident directed care as care directed by residents, including choosing the daily routines and services the resident wishes to receive. Front-line staff were given the power to make decisions related to patient care, and certain middle management positions were eliminated to provide resources for more direct-care staff. All employees received cross-training in multiple tasks, which, according to PMSV, gave them greater opportunity for advancement. Aides also received pay increases with each year of service, bonuses for staying with PMSV, and a full benefit plan, including health care and a pension.
Funding source	Private
Start date	1991
Evaluation findings	No formal evaluation has been conducted. However, since the implementation of the changes, turnover at PMSV is lower than the industry standard. In 1994, PMSV's turnover rate was 54 percent, in 1995 it was 39 percent, and in 1996 it was 37 percent.

	Wisconsin's Community Links Workforce Project
Affected provider type	Nursing homes, home health care agencies (and other long-term care providers)
Description	The state Bureau of Aging and Long Term Care Resources allowed counties to apply for funds to support local initiatives designed to strengthen or expand the community long-term care workforce. Thirty-two grants from 28 counties were funded, and included multidisciplinary collaborations to address the issue of aide recruitment and retention, efforts to tap nontraditional sources of workers, and programs to provide wrap-around services for aides, such as the establishment of emergency funds for unexpected car repairs and assistance with children's school supplies.
Funding source	Community Options Program and Community Options Program-waiver funds
Start date	1999
Evaluation findings	No evaluation conducted to date.

Table 10: Federal Research and Data Collection Initiatives

	Report to Congress on Appropriateness of the Minimum Nurse Staffing Ratios in Nursing Homes, Phase II—Health Care Financing Administration, HHS
Affected provider type	Nursing homes
Description	Phase II of the Staffing Ratio study will examine the costs and benefits associated with establishment of staffing minimums and further explore the findings of Phase I. Additionally, Phase II will examine issues that affect the recruitment and retention of nurse aides, including turnover rates, amount of staff training, and management of staff resources.
Funding source	Federal
Start date	2000, with an expected completion date of late 2001
Evaluation findings	No evaluation has been completed.

	National Study of Nursing Home Nurse Aides and Home Health Workers—Health Resources and Services Administration, HHS
Affected provider type	Nursing homes and home health care agencies
Description	The Health Resources and Services Administration recently began a national study of the current and future supply of and demand for front-line long-term care workers. The study will include analysis of existing databases and interviews of long-term care workers, providers, associations, and interested state agencies. The interviews will be conducted by the Center for Health Workforce Studies at State University of New York, University at Albany's School of Public Health, and other health workforce centers around the country. A report is expected in late 2001.
Funding source	Federal
Start date	2000
Evaluation findings	No evaluation has been completed.

	Frontline Workers in Long-Term Care—Office of Disability, Aging, and Long-Term Policy, Office of the Assistant Secretary for Planning and Evaluation, HHS
Affected provider type	All long-term care workers
Description	This project is designed to heighten the awareness of federal, state, and local policymakers about issues related to the development of a quality long-term care workforce. The project will identify successful recruitment and retention models for front-line long-term care workers and will suggest policy and research activities to promote a quality paraprofessional long-term care workforce. ASPE is collaborating with the Robert Wood Johnson Foundation. HCFA, HRSA, Administration on Aging, the Department of Education, Agency for Healthcare Research and Quality, and the Department of Labor are also involved.
Funding source	Federal and private
Start date	2000
Evaluation findings	No evaluation has been completed.

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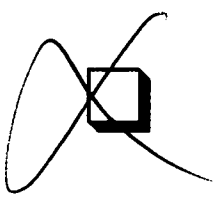

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